ROBICHAUD
chiropractic + orthotics
www.DocAdrian.com

Fill in pages 1 and 2, read page 3 & 4, but don't sign yet.

CONFIDENTIAL PATIENT CASE HISTORY

Name:_____ Date: _____

Address:_____
Residence and Mailing City Province/State Postal Code/Zip

Cellular Telephone Number: _____ Home Telephone Number: _____

Email:_____ Birth date:_____ Biological sex: _____
DD/MM/YY

Insurance Company: _____Policy #: _____ Member ID:_____

Have you had previous chiropractic care? ☐Yes ☐No Last Visit Date:_____

Medical Doctor's name and phone number:_____

Whom may we thank for referring you to our office?☐Google ☐Other:_____

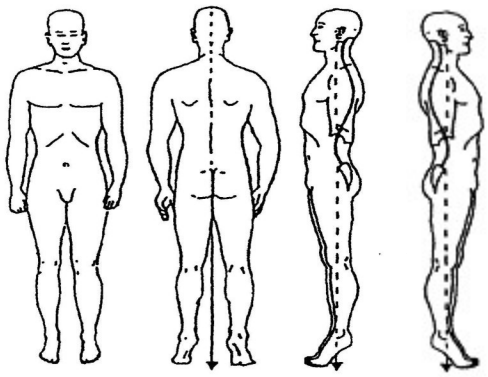
YOUR HEALTH PROFILE

Please briefly describe the chief area of complaint, including the effect it has had on your life, when you first noticed it, and how it originally occurred.

_____

_____

Indicate where you feel your symptoms on the diagram below:



Check the boxes that describe what you are feeling:

☐ Dull ☐ Sharp ☐Numbing ☐ Throbbing ☐Tingling ☐Aching ☐Burning ☐Stabbing ☐Cramping

☐Stiff ☐Spasms ☐Shooting ☐Pounding ☐Constricting ☐ Other:_____

When did it start? _____ It is: ☐About the Same ☐Getting Better ☐Getting Worse

What makes it worse?_____

How frequent is the complaint? ☐Constant ☐Daily ☐Intermittent ☐Night Only ☐ Other:_____

How long does it last? ☐ All day ☐A Few Hours ☐ Minutes ☐ Seconds

Is there anything you can do to relieve the problem? ☐Yes ☐No If yes describe: _____

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Name:_____ Date:_____

Please indicate your level of pain/discomfort below by checking a number/circling a word:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Normal *Mild* *Moderate* *Severe* *Excruciating*

*If your pain varies or you have multiple areas of pain at different levels, inform the doctor.

Please check (√) all symptoms you have had in the past year even if they do not seem related to your current problem.

- ☐ Headaches
- ☐ Neck Pain/ Stiffness
- ☐ Pins & Needles in Arms
- ☐ Pins & Needles in Legs
- ☐ Numbness in upper limb
- ☐ Numbness in lower limb
- ☐ Hypersensitive Eyes
- ☐ Buzzing/ringing in Ears
- ☐ Significant Irritability
- ☐ Mood Swings
- ☐ Severe Nervousness
- ☐ Considerable Fatigue
- ☐ Clinical Depression
- ☐ Severe Constipation
- ☐ Severe Diarrhea
- ☐ Significant Tension
- ☐ Fainting
- ☐ Dizziness
- ☐ Back Pain
- ☐ Cold Hands
- ☐ Cold Feet
- ☐ Problem Urinating
- ☐ Heartburn
- ☐ Ulcers
- ☐ Upset Stomach
- ☐ Loss of Taste
- ☐ Loss of Balance
- ☐ Loss of Smell
- ☐ Severe Menstrual Pain
- ☐ Menstrual Irregularity
- ☐ Fever in the past month
- ☐ Hot Flashes
- ☐ Sleeping Problems

Please note any major illnesses you have had: ☐Heart disease ☐Cancer ☐Diabetes Other: _____

_____

Please list any major accidents or surgeries you have had and when you had them: _____

_____

Please list any medications you are taking:_____

Payment is due when the service is rendered. We will provide receipts upon your request. Please note that many private insurance companies pay towards chiropractic care and custom made orthotics. Please consult your insurance plan for more details. If you have been injured at work or involved in a recent automobile collision, please let us know so we can arrange to bill on your behalf.

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION
CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

  The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

  Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

  Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

  The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____
Name (Please Print)

_____ Date: _____ 20 25
Signature of patient (or legal guardian)

_____ Date: _____ 20 25
Signature of Chiropractor